86-1.77 Reserved

86-1.78 Reserved

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86-1.80 Mergers, Acquisitions and Consolidations.

(a) Additional reimbursement for meeting costs associated with mergers, acquisitions, or consolidations on or after January 1, ~~[1991]~~ 1994. As used in this section, the terms merger, acquisition and consolidation shall mean the combining of two or more general hospitals licensed under article 28 of the Public Health Law, where such combination is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery. The provisions of this section shall apply only if the facilities submit a written request to the department at least 60 days prior to [~~the beginning of the rate period~~] July 1, 1994 for the rate period commencing January 1, 1994 and 60 days prior to January 1, 1995 for the rate period commencing January 1, 1995 for reimbursement of allowable costs associated with this merger, acquisition or consolidation. Rate period for purposes of this section shall mean January 1 to December 31.

(b) The allowable costs asocaited with a merger, acquisition, or consolidation shall mean, but not be limited to consulting and planning fees, settlement of monies owed to creditors, settlement of pension funds, or settlement of tax liabilities. Such costs shall not include interest, penalties, fines or repayments owed to third party payors for rate adjustments associated with implementation of this Subpart.

(c) In order to be eligible for reimbursement, the applicant facility must have previously received a certificate of need (CON) approval by the Commissioner and/or Public Health Council approval for the merger, aquisition, or consolidation pursuant to the Public Health Law. The allowable reimbursement shall be incorporated into the rate as a non-comparable cost in the Janaury 1 to December 31 rate period following receipt of the written request from the

hospital and final approval of the merger, acquisition, or consolidation. Allowable costs associated with a merger, acquisition, or consolidation shall not become part of the facility's operating cost base as determined pursuant to section 86-1.50(e) of this Subpart nor be reimbursed as capital costs.

(d) ~~[One million dollars a year]~~ For the rate period commencing January 1, 1994 up to three million dollars shall be allocated on a prorated basis for reimbursement to those facilities eligible pursuant to subdivisions (a), (b) and (c) of this section. For the rate period commencing January 1, 1995 up to three million dollars shall be trended pursuant to section 86-1.58 of this Subpart and shall be allocated on a prorated basis for reimbursement to those facilities eligible pursuant to subdivisions (a), (b) and (c) of this section. Any portion of allowable costs not reimbursed in a year shall be included in the prorated calculation for reimbursement in the following year. Any portion of the total [~~one million~~] dollars not

allocated in accordance with this section shall be reallocated to further fund the base year enhancements specified in clauses (c) and (d) of section 86-1.52(a) [(i)](1) (iv) and subdivision (c) of section 86-1.82 of this Subpart in the same proportion as their original funding.

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86-1.81 Development of rates of payment for Comprehensive cancer hospitals or ~~(exempt)~~ **acute** Children's Hospitals.

(a) For purposes of this subdivision, the following definitions shall apply:

(1) Comprehensive Cancer Hospitals shall be those general hospitals that are not reimbursed on a case-based payment per diagnosis-related group **basis** for inpatient services provided to beneficiaries of Title XVIII of the federal Social Security Act (Medicare) as a result of their designation by the secretary of the federal Department of Health and Human Services as such.

(2) ~~(Exempt)~~ **Acute** Children's Hospitals shall be those children's hospitals which provide inpatient acute care services and are not reimbursed on a case-based payment per diagnosis-related group **basis** for inpatient services provided to Medicare beneficiaries as a result of their [~~status~~] **designation** as an exempt **acute** children's hospital **as defined in 42 CFR 412.23(d), by the federal Department of Health and Human Services**.

(3) Patient days, for reimbursement purposes, shall be computed in accordance with section 86-1.9 of this Subpart except that medical-surgical patient days shall be determined by using the higher of the minimum utilization factor of 80 percent of certified medical-surgical beds or actual medical-surgical patient days of care furnished by the facility.

(4) Reimbursable operating costs shall be those operational costs computed on the basis of allowable fiscal data submitted by the medical facility for the calendar year 1987 (base year) or the fiscal year ended at least six months prior to January 1, 1989 (base year). This allowable fiscal data shall not include assessments made pursuant to sections 86-1.11(t) and 86-1.65(n) of this Subpart.

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(5) Non-Medicare exempt hospital costs shall be calculated by subtracting the Medicare share of the base year reimbursable costs from total base year reimbursable costs. The Medicare costs removed shall be calculated in accordance with section 86-1.54(c) of this Subpart except that the fiscal and statistical data utilized in such calculation shall be as reported on the hospital's Institutional Cost Report and Provider Statistical Reimbursement Report (Medicare) for 1987.

(b)Comprehensive Cancer Center General Rates of Payment. Hospital services, except for bone marrow transplantation services, provided in exempt comprehensive cancer centers shall be reimbursed on the basis of a per diem rate composed of:

(1)(i) An initial per diem operating cost component computed on the basis of allowable historical inpatient operating expense, for hospital services other than bone marrow transplant services, based on separately identifiable base year cost statistical data for the qualifying hospital. The base year Medicare share of these costs shall be removed in accordance with [~~subdivision~~] paragraph (a) (5) of this section. The non-Medicare exempt hospital operating [~~rate~~] cost component shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and further adjusted for changes in volume and case mix from the base year to the rate year using total reimbursable non-Medicare costs and statistics of the exempt hospital pursuant to section 86-1.64 of this Subpart.

(ii) The per diem rate shall be further adjusted to reflect costs incurred subsequent to the base year but not reflected on such base which are approved pursuant to section 86-1.61 of this Subpart.

(2) A capital per diem cost component computed on the basis of budgeted capital costs, except for capital costs otherwise allocated pursuant to subdivision (c) hereof, allocated to the exempt hospital [,] pursuant to the provisions of section 86-1.59 of this Subpart (or, in the case of hospitals for which separately identifiable cost and statistical data os not available, a

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statewide average capital cost per day for comparable exempt hospitals) divided by exempt hospital patient days reconciled to actual total expense; and

(3) A health care services allowance of .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospitals non-Medicare reimbursable inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(c) Comprehensive Cancer Center Specialty Rates of Payment.

(1) Bone Marrow transplantation services provided in exempt comprehensive cancer centers shall be reimbursed, upon the request of a comprehensive cancer center therefor, on the basis of a separate per diem rate composed of:

(i) (a) An initial per diem operating cost component computed on the basis of allowable historical inpatient bone marrow transplantation operating expenses based on separately identifiable base year cost and statistical data for the bone marrow transplant unit. The base year Medicare share of these costs shall be removed in accordance with paragraph (a) (5) of this section. The non-Medicare exempt bone marrow transplant operating cost component shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and further adjusted for changes in volume and case mix from the base year to the rate year using total reimbursable non-Medicare costs and statistics of the bone marrow transplant unit pursuant to section 86-1.64 of this Subpart. In the event that the bone marrow transplant unit is established subsequent to the comprehensive cancer hospital's base year, the initial per diem operating cost component shall be computed on the basis of separately identifiable budgeted costs and statistical data and subsequently adjusted to actual costs.

(b) The per diem rate shall be further adjusted to reflect costs incurred subsequent to the base year but not reflected in such base which are approved pursuant to section 86-1.61 of this Subpart.

(ii) A capital per diem cost component computed on the basis of budgeted capital costs allocated to the bone marrow transplantation unit, pursuant to the provisions of section 86-1.59 of this Subpart divided by the bone marrow transplantation unit patient days reconciled to actual total expense; and

(iii) A bad debt and charity care allowance, a health care services allowance and a financially distressed allowance as determined pursuant to the provisions of section 86-1.65 of this Subpart.

[~~(c)~~] (d) Rates of Payment for Acute Care Children's Hospitals. Hospital services provided to non-Medicare patients in acute care children's hospitals shall be reimbursed on a diagnosis-related group basis composed of:

(1) 1994 reimbursable operating costs computed on the basis of the hospital's reimbursable operating costs as defined in paragraph (a)(4) of this section and statistical data for the same period. The

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base year Medicare share of these costs will be removed in accordance with paragraph (a)(5) of this section. The non-Medicare hospital operating costs shall be trended to the rate year pursuant to section 86-1.58 of this Subpart and further adjusted for changes in volume and case mix from the base to the rate year using total reimbursable non-Medicare costs and statistics of the hospital pursuant to section 86-1.64 of this Subpart. The DRG specific operating cost component shall be computed utilizing one-hundred percent hospital specific reimbursable costs with no adjustment for long stay or high cost outliers pursuant to section 86-1.54(f)(1) and (3) of this Subpart.

(2) The acute care children's hospitals shall be eligible to participate in the financial incentives for the physician specialty weighting towards primary care.

(3) A capital cost component computed on the basis of budgeted capital costs allocated to the inpatient portion of the hospital pursuant to the provisions of section 86-1.59 of this Subpart, divided by the budgeted discharges and shall be reconciled to total actual expenses and discharges;

(4) A health care services allowance of .614 percent for rate year 1994 and .637 percent for rate year 1995 of the hospital's non-Medicare reimbursement inpatient costs computed without consideration of inpatient uncollectible amounts and after application of the trend factor described in section 86-1.58.

(5) Discrete long stay and high cost outlier rates of payment shall not be paid.